

APPLICATION FOR RETURN TO ACTIVE STATUS

Prior to returning to Active Status, a licensee must:

- **complete 100 hours of Continuing Professional Development (CPD) Credits, including a minimum of 40 Category 1 credits;**
- **complete the Board's Electronic Health Record (EHR) Proficiency requirement; and**
- **obtain professional liability insurance coverage. The requirement for professional liability insurance coverage applies only to physicians engaging in any direct or indirect patient care in Massachusetts.**

1. NAME: _____
(Print Name)

2. MAILING ADDRESS: _____

(City) (State) (Zip Code)

3. LICENSE REGISTRATION NUMBER: _____

4. HAVE YOU COMPLETED THE CPD REQUIREMENTS AS REQUIRED BY 243 CMR 2.06(6):

Check one: ☐ YES ☐ NO

Please provide the number of CPD credits completed in each category:

Category 1 credits _____ Risk Management Category 1 credits _____

Category 2 credits _____ Risk Management Category 2 credits _____

5. DEMONSTRATING EHR PROFICIENCY:

- ☐ I have demonstrated proficiency in the use of EHR by completion of 3 hours of a Category 1 EHR-related CPD course that discusses, at a minimum, the core and menu objectives and the Clinical Quality Measures for Meaningful Use; or
- ☐ I am exempt from the EHR Proficiency requirement, during this licensing cycle because:

Check one:

- ☐ I will not be engaged in the practice of medicine as defined in 243 CMR 2.01(4); or
- ☐ I am on active duty as a member of the National Guard or of a uniformed service called into service during a national emergency or crisis.

6. PROFESSIONAL LIABILITY INSURANCE: As a condition of rendering any direct or indirect patient care in the Commonwealth, a physician is required to obtain medical malpractice insurance. Please provide the following information:

☐ Name of Carrier _____

Policy Start Date: _____

Policy End Date: _____

Coverage Type:

☐ Claims with tail coverage

☐ Occurrence Policy

☐ Letter of Credit: ☐ YES ☐ NO (If “yes”, you must provide documentation.)

☐ I am exempt from the requirement to obtain medical malpractice insurance for the following reasons:

☐ I am not involved in any direct or indirect patient care

☐ I am otherwise exempt (please specify below)

APPLICANT'S STATEMENT

I hereby certify under the penalties of perjury that all information on this application is true.

SIGNATURE: _____

DATE: ____/____/____

EMAIL ADDRESS: _____

Please fax the completed form to the attention of the Renewals Coordinator at the Board of Registration in Medicine at (781) 876-8383.